Strategic Use of Population-Based Data for Improving Health

How We Use Health Information

Presenter:

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Miami Behavioral Health Center
"Por Tu Salud"

Cohort: Cohort III (Awarded September 2010)

Type of program: PBHCI for indigent adults with SPMI receiving behavioral health care services in our agency (located in a primarily Hispanic/Latino community)

Primary Care Model: Primary care clinic (awarded FQHC status in 2012) in a community-based behavioral health care agency

Who plays a role in collecting and using H Indicators data to improve health outcomes?

- **Medical Assistant**
  - takes vitals
  - draws blood
- **ARNP**
  - analyzes blood work results
  - discusses results with patients
- **Research Assistant & Peer Evaluator (Evaluation)**
  - retrieve H data
  - enter data in TRAC
  - generate quarterly reports
- **Wellness Coordinators**
  - review vitals/blood work and reinforce ARNP recommendations

How we use Health Indicators data to promote the aims of the PBHCI Initiative?

A. How are H Indicators collected and by whom?
(additional data we use to improve health outcomes)
B. When is data collected?
C. Where is the data stored?
D. Who enters H data?
E. How is data retrieved?
F. What kinds of data do you retrieve
G. How is data used to improve outcomes?

- ❑ Wellness programming (individual and group services)
- ❑ Development of individualized care plans
- ❑ Monitoring progress

A. How are H Indicators collected and by whom?

Medical Assistant (MA)

- takes vitals and records in EHR
- draws blood
- sends sample to lab

Laboratory

- processes sample
- sends results to clinic within 2-3 business days

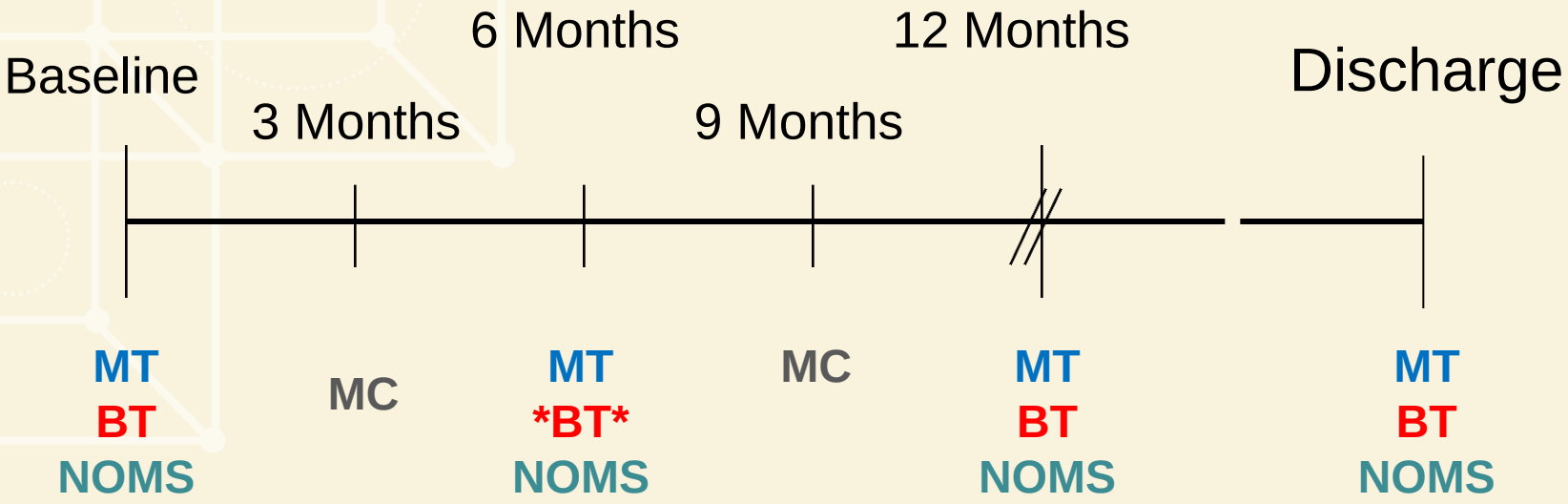
Administrative assistant(s) and/or MA

- upload results (PDF) to HER

Research Assistant

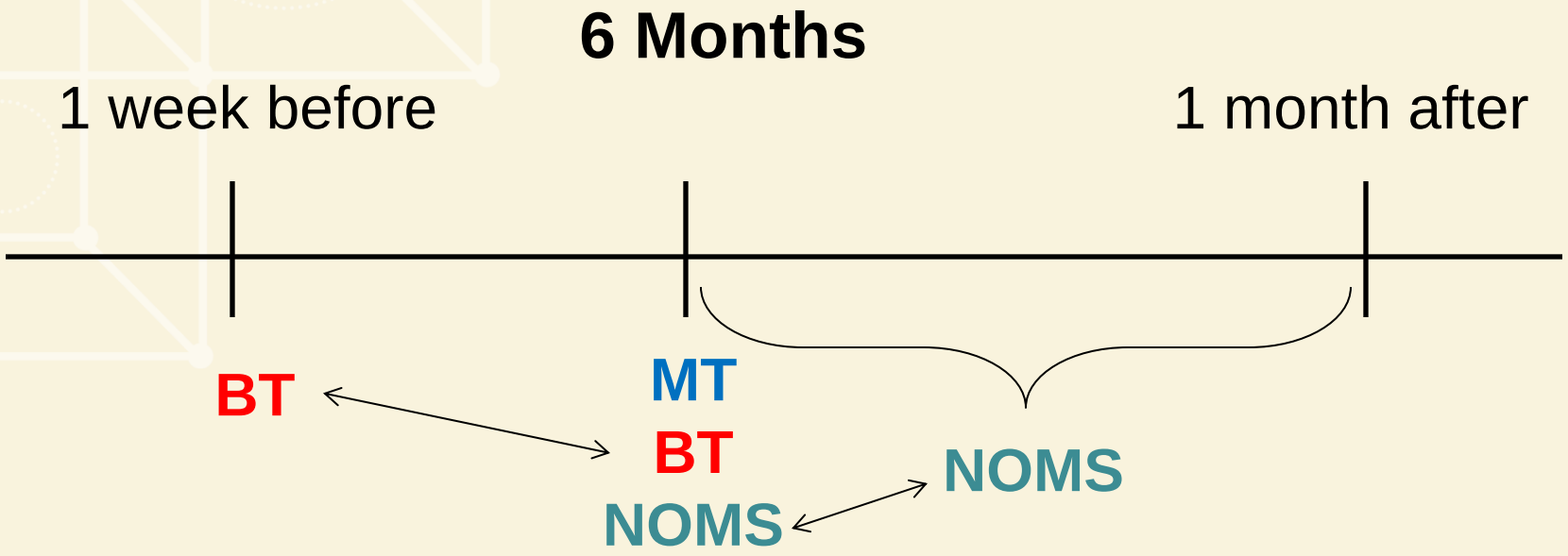
- retrieves H data from EHR
- records in NOMs
- enters data in TRAC

B. When is data collected?



MC = Mechanical Indicators: Collect and store in medical records
MT = Mechanical Indicators: Collect, store in medical records, and enter in TRAC
BT: Blood work: Collect, store in medical records, and enter in TRAC
NOMS = NOMs survey, enter in TRAC

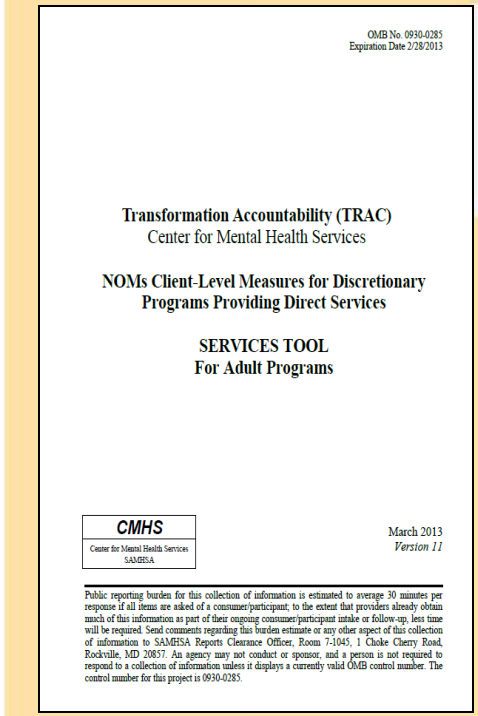
B. When is data collected?



B. When is data collected?

The Wellness Coordinators sometimes monitor consumers' **weight** and **blood pressure** more often between quarterly visits.

C. Where is the data stored?



OMB No. 0930-0285
Expiration Date 2/28/2013

Transformation Accountability (TRAC)
Center for Mental Health Services

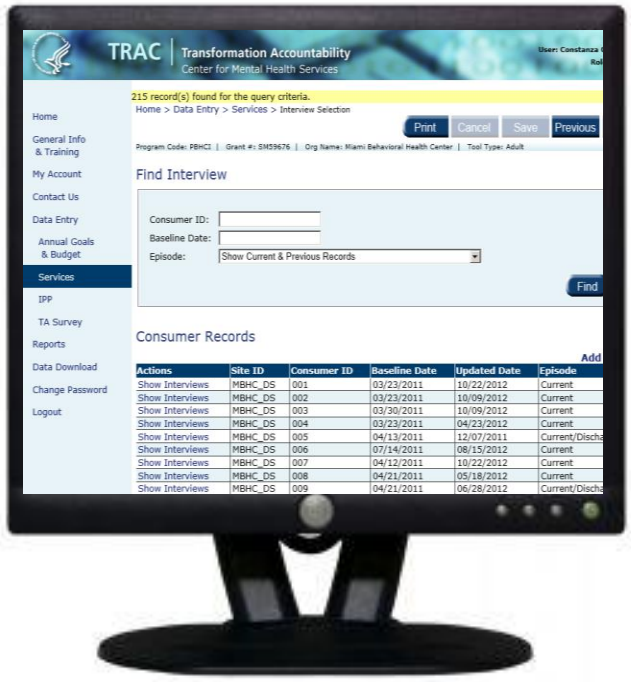
NOMs Client-Level Measures for Discretionary Programs Providing Direct Services

SERVICES TOOL
For Adult Programs

CMHS
Center for Mental Health Services
SAMHSA

March 2013
Version 11

Public reporting burden for this collection of information is estimated to average 30 minutes per response if all items are asked of a consumer/participant, to the extent that providers already obtain much of this information as part of their ongoing consumer/participant intake or follow-up, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1045, 1 Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0285.



D. Who enters H data?

- Uploading to EHR
  - Medical Assistant
  - Administrative Assistant(s)
- Entering in TRAC
  - Research Assistant
  - Peer Evaluator

E. How is data retrieved?

EHR

- Medical staff
- Wellness Coordinators
- Evaluation staff

TRAC (WesDax)

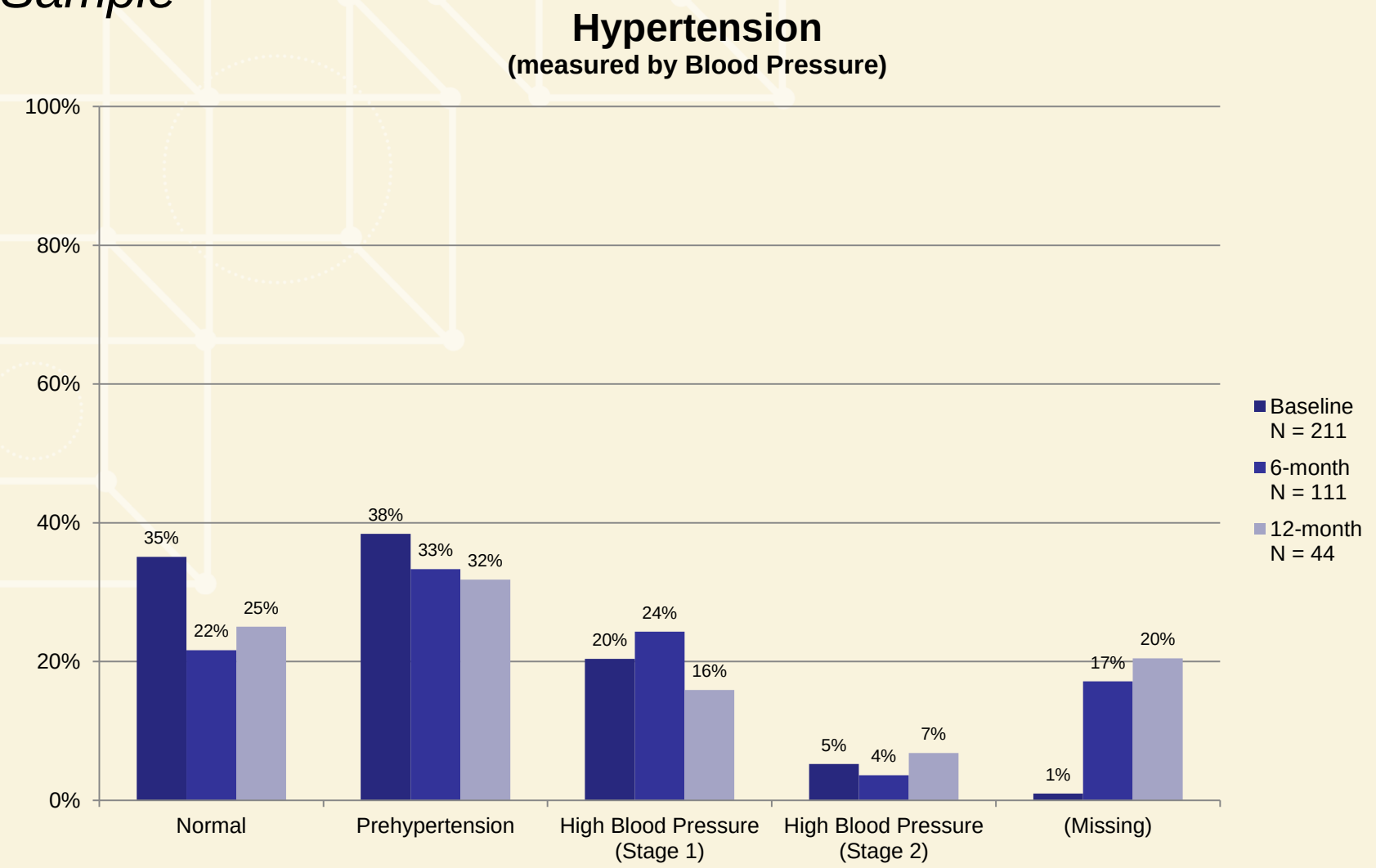
- Evaluation Director
- Research Assistant

F. What kinds of data do we retrieve?

Section H

- Systolic BP
- Diastolic BP
- Weight
- Height
- BMI
- Glucose
- HgbA1c
- Total Cholesterol
- HDL Cholesterol
- LDL Cholesterol
- Triglycerides

Sample


Hypertension
(measured by Blood Pressure)
100%
80%
60%
40%
20%
0%
35%
22%
25%
38%
33%
32%
20%
24%
16%
5%
4%
7%
1%
17%
20%
Normal
Prehypertension
High Blood Pressure (Stage 1)
High Blood Pressure (Stage 2)
(Missing)
Baseline N = 211
6-month N = 111
12-month N = 44

G. How we use H data to improve outcomes?

- Wellness programming (individual and group services)
  - Exercise routines
  - Wellness Fairs
  - Diabetes library
  - Smoking cessation program
- Development of individualized integrated care plans
  - "Progress Report" for consumers
- Progress monitoring
  - Wellness Coordinators monitor BP, weight loss, high risk, and referrals

Purpose of Progress Report

- Evaluation and discussion of client's progress based on lab results and Doctor's Progress Notes
- Provision of individual educational session for client to accomplish healthier lifestyles
- Setting individualized goals for achieving healthier lifestyles.



[ ], here are your most recent physical health indicators:

The physical health indicators we collect tell us whether your health is at risk. The chart below highlights the areas where you have improved.

Physical Health Indicators	Baseline [ ]	6M [ ]	12M [ ]	18M [ ]	24M [ ]
Weight					
Body Mass Index (BMI) Your body fat based on your weight and height *At risk if 25 or higher*					
Blood Pressure The force of your heart pumping blood through your veins *At risk if 140 or higher*					
Glucose How much sugar is in your blood *At risk if 100 or higher*					
HbA1c Another measure of how much sugar is in your blood *At risk if 5.7 or higher*					
Total Cholesterol *At risk if 200 or higher*					
HDL Cholesterol Good cholesterol *At risk if less than 40*					
LDL Cholesterol Bad cholesterol *At risk if 130 or higher*					
Triglycerides Fats carried in blood like excess calories, alcohol, or sugar *At risk if 150 or higher*					
You rated your overall health as:	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

Recommendations (to be completed by the Wellness Coordinator):

_____

_____

_____

_____

Goals (to be completed by [ ]):

_____

_____

_____

_____

Your next appointment is on: _____

Reviewed by:

_____ ([ ])

_____ (Wellness Coordinator)



Implementation Process

- Client gets labs done
- WC checks Dr's Progress Notes and Labs on MD Flow
- WC contact client to coordinate appointment to complete progress report.
- At the appointment time WC completes the physical health indicators part.
- WC educate client on each physical health indicator to maintain a healthy lifestyle.
- WC writes recommendations to the client based on lab results and Dr' s PNs
- Client writes his/her own goal in order to accomplish desired healthier lifestyle
- WC gives appointment for follow up.
- Both WC and Client sign the progress report.

Mayda, aquí están sus indicadores de salud física mas recientes:

Los indicadores de salud física que analizamos nos dicen si su salud esta en riesgo. Esta tabla destaca las áreas donde usted ha mejorado:

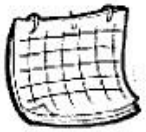
Indicadores de salud física	Inicio 5/8/12	6M 11/8/12	12M	18M	24M
Peso	157	162			
Índice de Masa Corporal (IMC) Su grasa corporal basada en su peso y altura *En riesgo si es 25 o mas*	31	32			
Presión Arterial El esfuerzo de su corazón al bombear sangre por sus venas *En riesgo si es 140 o mas*	113	148			
Glucosa La cantidad de azúcar en su sangre *En riesgo si es 100 o mas*	94	90			
HbA1c Otra medida del azúcar en su sangre *En riesgo si es 5.7 o mas*	5.5	5.5			
Colesterol Total *En riesgo si es 200 o mas*	291	276			
Colesterol HDL El colesterol bueno *En riesgo si es menos de 40*	50	49			
Colesterol LDL El colesterol malo *En riesgo si es130 o mas*	203	168			
Triglicéridos Grasas en la sangre (el exceso de calorías, alcohol, y azúcar) *En riesgo si es150 o mas*	188	345			
Usted califico su salud general como:	Mala	Mala	Mala	Choose an item.	Choose an item.

Recomendaciones (debe ser llenado por el Coordinador de Bienestar):

-cumplir con tratamiento medicamentoso
-cumplir con recommendaciones de su doctor, ejemplo: dieta baja de sal y grasa
-incrementar ejercicios físicos

Objetivos/Metas (debe ser llenado por Mayda):

- Yo voy a esforzarme para hacer la dieta
- Voy a tratar de caminar y hacer ejercicio
- Cumplir con tomar los medicamentos.
-

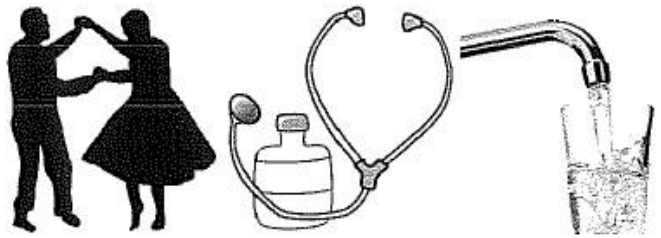


Su próxima cita es: _____

Revisado por:

X _____ (firma de Mayda)

_____ (firma de Coordinador de Bienestar)



Successes:

- Improvements on attendance rate to wellness groups
- Improvements on levels of Cholesterol, blood sugar, and blood pressure
- Improvements on motivation to continue visiting PCP
- Improvements on individuals self esteem

Barriers:

- Transportation to the appointment with WC, doctor/nurse, and wellness groups
- Lack of supplies in case of diabetic population to be able to monitor their levels of blood sugar
- Cultural issues related to self medication, eating habits
- Homelessness/low income that can get on their way to comply with medication management.